

Welcome to

SILVA CHIROPRACTIC

Thank you for choosing our office for chiropractic care. We are committed to providing your family with the highest quality of corrective and wellness chiropractic care available so that you and your family can enjoy an active, healthy, life. We will be working together to help you and your family reach your health and wellness goals.

If you ever have any questions about your chiropractic care, please don't hesitate to ask one of our highly educated chiropractic team members. All of your questions, even the ones you haven't even thought of yet, will be answered during your Chiropractic Report and your Human Potential Program.

We look forward to a long, healthy relationship with you and your family.

SILVA CHIROPRACTIC



Confidential Patient Health Information

Personal Information:

Name: _____
First Middle Last Sex
 M F

E-mail address: _____

Address: _____ City/ST _____ ZIP: _____

Home Phone: () ____ - ____ Work Phone: () ____ - ____ X ____ Cell Phone () ____ - ____

SS#: ____/____/____ Birthdate: ____/____/____ Marital Status: ____ (Married, Single, Other)

Employer: _____ Occupation: _____

Nearest Relative: _____ Relationship: _____ Phone: () ____ - ____

HOW WERE YOU REFERRED? _____

Reason for your Visit:

Have you been to this clinic before? Yes No

Purpose of this appointment _____

Reason for your visit is a result of (please circle): Wellness, Work Injury, Auto Accident, Trauma, Chronic Problem, Other

Please describe the pain and its location: _____

Pains are: Sharp Dull Constant Intermittent

Date of accident/injury, or when condition began: ____/____/____

Is condition getting worse? Yes No Staying the Same Comes and goes

Is this condition interfering with your: Work Sleep Daily Routine Other

Have you been treated by another doctor for this condition? Yes No

If yes, please name doctor/health care facility: _____

Insurance Information:

Company Name: _____ Phone: () ____ - ____

Address: _____ City/ST: _____ ZIP: _____

Name of Insured: _____ SS#: ____/____/____

Insured ID (if different than SS#): _____ Insured's Birthdate: ____/____/____

Policy/Group #: _____ Plan Name: _____

Relationship to you: _____ Insured's Employer: _____ Effective Date: ____/____/____

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Number of Children and Ages

Name _____
 Name _____
 Name _____
 Name _____

Age ____ Yes ___ No ___ Reason _____
 Age ____ Yes ___ No ___ Reason _____
 Age ____ Yes ___ No ___ Reason _____
 Age ____ Yes ___ No ___ Reason _____

Previous Chiropractic Care?

You deserve to be healthy. Life is a miracle and so are you. When you were created, you were given all the blueprints, intelligence, tools, and systems to live an active healthy life. Unfortunately, your health can be interfered with through accidents and challenges that cause a disruption to your health expression. Through your examination and through your lifetime involvement in chiropractic care, we will work to remove these interferences to your natural health expression so that you can live the quality of life you deserve.

	<i>Patient</i>	<i>Spouse</i>	<i>Child#1</i>	<i>Child#2</i>	<i>Child #3</i>	<i>Chiropractor's Comments</i>
Circle all that Apply						
1. Was Your Birth Traumatic?						
Long Delivery?	Y	Y	Y	Y	Y	_____
Difficult Delivery?	Y	Y	Y	Y	Y	_____
Forceps?	Y	Y	Y	Y	Y	_____
Caesarian?	Y	Y	Y	Y	Y	_____
Breach/cephalic?	Y	Y	Y	Y	Y	_____
Home birth?	Y	Y	Y	Y	Y	_____
Mother given drugs during delivery	Y	Y	Y	Y	Y	_____
Induced Labor?	Y	Y	Y	Y	Y	_____
2. Growth and Development						
Did you ever once...						
Learn to care for your spine?	Y	Y	Y	Y	Y	_____
Fall out of bed?	Y	Y	Y	Y	Y	_____
Bang your head?	Y	Y	Y	Y	Y	_____
Breastfeed?	Y	Y	Y	Y	Y	_____
Childhood sickness?	Y	Y	Y	Y	Y	_____
Have any Accidents?	Y	Y	Y	Y	Y	_____
Have Surgery?	Y	Y	Y	Y	Y	_____
Take Drugs?	Y	Y	Y	Y	Y	_____
Fall while learning to walk?	Y	Y	Y	Y	Y	_____
Bullied by your siblings?	Y	Y	Y	Y	Y	_____
Child abuse	Y	Y	Y	Y	Y	_____
Spanking?	Y	Y	Y	Y	Y	_____
Pulled ear/chin	Y	Y	Y	Y	Y	_____
Other	Y	Y	Y	Y	Y	_____
Chair pulled out when sitting?	Y	Y	Y	Y	Y	_____
Fall down the stairs?	Y	Y	Y	Y	Y	_____
Pulled by your arm?	Y	Y	Y	Y	Y	_____
Experience other traumas?	Y	Y	Y	Y	Y	_____
3. Current Health Habits						
Did/do you...						
Smoke?	Y	Y	Y	Y	Y	_____
Drink	Y	Y	Y	Y	Y	_____
Diet (do you eat healthy foods?)	Y	Y	Y	Y	Y	_____
Have you been in accidents?	Y	Y	Y	Y	Y	_____
Drugs? (Prescriptive or Non-Prescriptive)	Y	Y	Y	Y	Y	_____
Have Teeth Problems?	Y	Y	Y	Y	Y	_____

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Have Eye Problems?	Y	Y	Y	Y	Y	_____
Have Hearing Problems?	Y	Y	Y	Y	Y	_____
Exercise regularly?	Y	Y	Y	Y	Y	_____
Have sleeping problems? (nightmares)?	Y	Y	Y	Y	Y	_____
Have occupational stress?	Y	Y	Y	Y	Y	_____
Have physical stress?	Y	Y	Y	Y	Y	_____
Have mental stress?	Y	Y	Y	Y	Y	_____
Have hobbies/sports injuries?	Y	Y	Y	Y	Y	_____
Sleeping posture – side–stomach–back	_____	_____	_____	_____	_____	_____

Other symptoms:

- | | | |
|--|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Light Bothers Eyes |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Loss of Memory |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Ears Ring |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Loss of Smell |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Taste |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Depression | <input type="checkbox"/> Diarrhea |
| | | <input type="checkbox"/> Feet Cold |
| | | <input type="checkbox"/> Hands Cold |
| | | <input type="checkbox"/> Stomach Upset |
| | | <input type="checkbox"/> Constipation |
| | | <input type="checkbox"/> Loss of Balance |
| | | <input type="checkbox"/> Buzzing in Ear |

Have you been under drug and medical care? _____

What medications are you taking? _____

How Long? _____ Have you had surgery for this condition? _____ What and When?

What side effects have you experienced from the drugs and surgery? _____

Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Upon the completion of your first visit, you will receive a Chiropractic Report to discuss the different types of Active Life Plans that are available to you. Chiropractic Active Life Plans are designed to help get you feeling better quickly and to help you and your family be as healthy as possible. Please review the explanations of the Chiropractic Active Life Plans prior to your Chiropractic Report appointment so you can choose the level of participation that supports you in reaching all of your health goals.

As a result of my chiropractic care, I would like to

Please check all that apply

- | | |
|---|---|
| <input type="checkbox"/> Feel better quickly | <input type="checkbox"/> Have a healthier body by keeping my nerve system healthy |
| <input type="checkbox"/> Have a healthier spine | <input type="checkbox"/> Live a healthier lifestyle |

Signature

Date

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A restriction in the normal movement of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you to seek the services of a health care provider who specializes in that area.

We do not offer to treat any disease except the vertebral subluxation. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

(signature)

(date)

Office Fee Schedule and Financial Policy

<u>Service</u>	<u>Medicare</u>	<u>Cash Patient</u>	<u>Insurance Patient</u>
Consultation:	N/C	N/C	N/C
Initial Exam:	\$80	\$75	\$80
Dynamic Exam:	\$60	\$55	\$60
X-Rays:	\$40-100	\$40-100	\$40-100
Therapy and Rehab:	\$20-45	\$20-45	\$20-45
Adjustment:	\$27.14-37.40	\$40	\$45

Financial Policy and Chiropractic Active Life Plans

We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. **You will be expected to pay for your chiropractic care at the time the service is rendered unless a previous arrangement has been made.**

- Medicare:** We are a non-participating provider with Medicare. All that means is that you pay at the time of service and you will receive the reimbursement from Medicare. As a service to you, we will bill your services to Medicare for you. At this time Medicare only reimburses for chiropractic adjustments of the spine to correct subluxations. All exams, x-rays, and therapies are not covered by Medicare and are therefore your responsibility.
- Health Insurance:** At Silva Chiropractic, we base our care on what is best for you and your family. Therefore, we have chosen not to contract with any insurance company because it would prevent us from offering the best care possible. You will be responsible for the full balance for your care. If you have health insurance that has "Out of Network Benefits" that covers chiropractic care, we will bill them for you and you will receive the reimbursement.
- Cash Patient (Self pay):** You qualify as a cash patient if you either a.) have health insurance that doesn't have "Out of Network Benefits" or b.) you don't have health insurance. By not having to bill an insurance company, we save time and money. **We pass on the savings to you by giving you a special discount as indicated by the fee schedule above.** As a cash patient, you can pay for your care at the time of each visit, or to speed up your appointments you can prepay weekly, monthly, or yearly.

As a cash patient, you will not get receipts to submit to your insurance company. You can, however, be given a receipt for tax purposes or a medical savings account (MSA) indicating the total amount you have paid for chiropractic care during the year.

If you acquire insurance for a special situation such as an auto accident, our regular office fees will be charged to the insurance until such claim is settled.

I have read and I understand the above policies. I have initialed the one that applies to me.

Patient Signature

Date

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for care, payment and healthcare operations. For example:

Health Care

We may use or disclose your health information to a physician or other healthcare provider providing care to you.

Payment

We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations

We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization

In addition to our use of your health information for your care, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends

We must disclose your health information to you, as described in the Patient Rights Section of this Notice. We may disclose health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care

We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosure. In the event of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up x-rays or other similar forms of health information.

Marketing Health-Related Services

We will not use your health information for marketing communications without your written authorization.

Required by Law

We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect

We may disclose your health information to appropriate authorities if we can reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security

We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody or protected health information of inmate or patient under certain circumstances.

Appointment Reminders

We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Dr. Shawn Silva D.C.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give this Notice about our privacy practices, and our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect 4/02/07. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed in this Notice.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed in this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address in this Notice. If you request copies, we will charge you \$0.20 cents for each page, \$10.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed in this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 7 years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use of disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means, or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the Office for Civil Rights. We will provide you with the address to file your complaint with the Office for Civil Rights upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with the Privacy Officer or with the Office for Civil Rights.

Privacy Officer Dr. Shawn Silva, D.C. (408) 776-8608 Fax: (408) 762-2012 Address:18525 Sutter Blvd. Suite 170 Morgan Hill, CA 95037

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

This form does not constitute legal advice, and covers only federal, not state, law in effect or proposed as of August 14, 2002. Subsequent law changes may require Form revision.

Patient Signature _____ Date: _____
Witness Signature _____ Date: _____